MASSAGE CONFIDENTIAL CLIENT INFORMATION

Name _____ Date of Birth_____

Address _____

Phone (H) _____ (W) _____(MOB) _____

Occupation _____ e-mail _____

Have you had a professional massage before? Yes/No Type:_____

How did you hear about this place?_____

Your reason for this visit:_____

_____

Are there any areas of your body that you **DO NOT** want massaged: (Face) (Scalp)(Neck)(Shoulders) (Stomach) (Upper back) (Mid back) (Lower back) (Arms) (Hands)(Gluteals) (Legs) (Feet)

*Please list any accidents you have had in the past:_____

_____

* Please list any allergies you may have:_____

* Please list any diseases you may have:_____

_____

* Please list any medications you are taking:_____

_____

*Is there anything else I should know about?_____

_____

Do you wear: Contact Lens: Yes/No Dentures: Yes/No Hearing Aid: Yes/No

Any difficulty lying on your back, front, side, or turning?_____

List other therapies you receive: _____

Do you require Dry Needling in your treatment? Yes/No: Where?_____

Please complete the back of this form ➡

INFORMED CONSENT (PLEASE READ AND SIGN)

I, _____, understand that the massage therapy given to me by the massage therapist is to reduce stress, pain reduction, pain and muscle
tension and to increase circulation.

*I understand that massage therapy does not diagnose illness or disease, or any other disorder, and that the massage therapist does not prescribe medical treatment or pharmaceuticals.

*I understand that massage therapy is not a substitute for medical examinations or medical care, and that it is recommended that I am concurrently receiving treatment from my primary caregiver for any medical condition I may have.

*I understand that I have the right to refuse massage to any part of my body (Please let the therapist know). I have stated all my known physical conditions, medical conditions, and medications, and I will keep the massage therapist updated on any changes.

*I agree to honor the 24-hour cancellation policy or else be responsible for payment of the appointment fee that would have been due.

I understand that the services provided are not a replacement for medical or psychological care and that any information provided is not prescriptive or diagnostic in nature and is for educational purposes only. I also give my permission for the massage therapist to discuss relevant information treatment with my other health
care professionals.

NB: Please note that Peter is registered with most but not all private health funds. The onus is with the client to check with their health fund provider for any rebate. We don't have the ability to track the constant changes occurring with private health funds. We do not cover any gap payment.

Client Signature_____ Date_____

Massage at Armadale
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